BERISH STRAUCH, M.D.

PLASTIC AND RECONSTRUCTIVE SURGERY

AESTHETIC SURGERY SURGERY OF THE HAND

PROFESSOR AND CHAIRMAN
DEPARTMENT OF PLASTIC AND RECONSTRUCTIVE SURGERY
ALBERT EINSTEIN COLLEGE OF MEDICINE
MONTEFIORE MEDICAL CENTER

3331 BAINBRIDGE AVENUE BRONX, NEW YORK 10467 TELEPHONE: 212-920-5551 FAX: 212-798-0909

1123 PARK AVENUE NEW YORK, NEW YORK 10028 TELEPHONE: 212-534-5550

September 5, 1991

To Whom it May Conern.

Re: Ron Giladi

Please be advised, Mr. Giladi is to be scheduled for a decompression of his left median nerve at the wrist and the left ulnar nerve at the elbow and wrist.

If there is any further information I can provide, I would be most happy to do so.

Sincerely,

Berish Strauch, M.D.

BS:ew

BERISH STRAUCH, M.D. PLASTIC AND RECONSTRUCTIVE SURGERY AESTHETIC SURGERY SURGERY OF THE HAND

PROFESSOR AND CHAIRMAN
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ALBERT EINSTEIN COLLEGE OF MEDICINE
MONTEFIORE MEDICAL CENTER

3331 BAINERIDGE AVENUE BRONX, NEW YORK 10467 TELEPHONE: 212-920-5551 FAX: 212-795-0909

1123 PARK AVENUE NEW YORK, NEW YORK 10028 TELEPHONE: 212-534-550

October 21, 1991

To Whom It May Concern,

Re: Ron Giladi

Mr. Giladi is scheduled for decompression of his left median nerve at the wrist and the left ulnar nerve at the elbow and wrist. Post-operatively, Mr. Giladi will require a 4 week healing period.

If there is any further information I can provide, I would be most happy to do so.

Sincerely,

Berish Strauch, M.D.

BS:ew

BERISH STRAUCH, M. D.
PLASTIC AND RECONSTRUCTIVE SURGERY
AND SURGERY OF THE HAND
3331 BAINBRIDGE AVENUE
BRONX, NEW YORK 10467

TELEPHONE: (212) 920-5551

PROFESSOR AND CHIEF PLASTIC SURGERY DIVISION: ALBERT EINSTEIN COLLEGE OF MEDICINE AND MONTEFIORE MEDICAL CENTER

February 4, 1992

To Whom It May Concern,

Re: Ron Giladi

Please be advised, the above captioned patient must continue his physical therapy as part of his recovery from the decompression of his median nerve. Physical therapy helps de-sensitize as well as full range of motion. This is the standard follow-up to a decompression surgery. Mr. Giladi is to continue his therapy until further notice.

If there is any further information I can provide I would be most happy to do so.

Berish Strauch, M.D.

BS:ew

BERISH STRAUCH, M.D.

AESTHETIC SURGERY

SURGERY OF THE HAND

PROFESSOR AND CHAIRMAN.

DEPARTMENT OF PLASTIC AND RECONSTRUCTIVE SURGERY

ALBERT EINSTEIN COLLEGE OF MEDICINE

MONTEFIORE MEDICAL CENTER

3331 BAINBRIDGE AVENUE BRONX, NEW YORK 10467 TELEPHONE: 212-920-5551 FAX: 212-798-0909

1123 PARK AVENUE NEW YORK, NEW YORK 10028 TELEPHONE: 212-534-5550

July 30, 1991

To whom it may concern,

Re: Ron Giladi

Mr. Giladi is a 39 year old Israeli Captian working as a video photographer at Albert Einstein College of Medicine, who on September 5, 1987, sustained a penetrating injury to his left forearm with incomplete severence of his left median nerve. He underwent repair at that time. More recently, he returned because of bilateral compression of his median nerve at the wrist as well as symptoms secondary to an cervical injury. EMG's and Conduction studies documented that bilateral median nerve compression at the wrist as well as bilateral ulnar nerve contrapments at his elbow. Additionally, there was a left C6 radicular function resulting in a mild degree of axon loss.

On physical examination, the patient has decreased sensibility in all of his digits as well as a weakness of his thenar musculature and long flexors to the little fingers.

I believe that until these clinical problems are resolved, Mr. Giladi will be unable to perform his usual activities during army service.

If there is any further information I can provide, I would be most happy to do so.

Sincerely,

Berish Strauch, M.D.

BS:ew dictated but not read

SPECIAL DISCRECATION

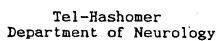
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1300 MOFFIS PARK AVE Bronx 1.4. LOHGI
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n to your opinion, is this disability the resu	of Injury arising out of and in the co	urse of employment or o	ccupational disease?	1 Yes	
Il "Yes," has Form C-4/48 been filed wi	th the Workers' Compensation Board?	Yes No			
REMARKS (attach additional sheet, If nec	essary)				
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NOTICE AND P	ROOF OF CLAIM FOR DISA	RII ITY RENEEITS		
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AUTHORIZATION TO PAY BENEFITS TO HEALTH CARE PROVIDER. I hereby authorize payment directly to the Health Care Provider whose signature is above



ID: Name:

Giladi Roni

Invest No.: Invest Date:

92.12.31

Date of Birth: 52.03.05

Age:

40

Sex:

Height:

180 cm

EMG Physician:

M.Sadeh

Referring Department: Referring Physician:

Clinical findings:

S/p operation for lt CTS and lt ulnar neurolysis (12.12.91). Since the operation numbness in hand and fingers 4 and 5.

Reason for referral:

Evaluation of median and ulnar nerves.

Summary:

The 1t median motor latency is borderline, but the sensory latency is markedly prolonged. The sensory distal latency of the rt median nerve is simillarly prolonged.

The lt ulnar motor distal latency is mildly prolonged. The velocity is normal between elbow and hand, but reduced along the ulnar groove at the elbow. There is no decrease in amplitude along the elbow. The sensory distal latency is prolonged and amplitude reduced to less than half of the rt side. Velocity is normal.

Diagnosis:

Bilateral CTS.

Ulnar neuropathy m/p due to injury at the elbow.

M. Sadeh. MD

DATE OF SURGERY_

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P B. STR'AUCH PLS
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TELEPHONE 920-5551

BNDD NO. AB1837078

BERISH STRAUCH, M. D.
PLASTIC & RECONSTRUCTIVE SURGERY
AESTHETIC SURGERY
SURGERY OF THE HAND

THE HAND
3331 BAINBRIDGE AVENUE BRONX, NEW YORK 10487
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Office address 333/Bn		onx 214 10467
Number :	Street City or Town V. Practitioner's SS No.	State Zio Code All others T.I.N.
01612	26 3330	
REPORT OF SERVICES.	D	Procedure CD9/CPT4 Charges
Date of Services Place of Services	Description of Services Rendered	C.S/CF14 Charges
		Total
AUTHORIZATION TO PAY BENEFITS TO HEALTH CARE	E PROVIDER: I hereby authorize payment directly to	the Health Care Provider whose signature is above.
Memcer's signature		

NOTICE AND PROOF OF CLAIM FOR DISABILITY BENEFITS	و مهر بالهامين موسوس بسيد و برا آدي سيد و ميا مسيده و ما دو مسيد و و مشاهد .
IMPORTANT: Use this form only when the Member becomes sick white employed to taken 3 10 of disabled within four (4) ment. Otherwise use green claim form DB-300.	weeks after termination of employ-
PART B HEALTH CARE PROVIDER'S STATEMENT (please print or tyce)	
The health care provider's statement must be filled in completely and mailed to the Fund or returned to the member within seven (7-d, give approximate date. Make some estimate, Delay in the payment of Disability Benefits may be prevented. If disability is displayed, enter estimated, givery date under "Remarks."	7) days of receipt of the form. For item
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b. Date of your most recent treatment for this disability	
c. Date member was unable to work because of this disability	
d. Date member will be able to perform usual work	12 91
	- 6 5 2
(Even if considerable question exists, estimate date. Avoid use of terms such as unknown or undeter	mined.)
I. In your opinion, is this disability the result of injury arising out of and in the course of employment or occupational disease?	T Yes TWO
If "Yes," has Form C-4/48 been filed with the Workers' Compensation Board? ☐ Yes ☐ No	
REMARKS (attach additional sheet, if necessary)	
The investment of the state of	
Licensed in the State of Licensed in the State	cense No. 085 58
Dieck R	
Par Seco Hanny	1 No
Health Care Provider's signature	Date
Health Care Provider's name (please print)	
7771 / 1 Id No.	,
	276 >
(Must be furnished under authority of law) India Prestitionario CO N	Zp Code
All Outers I,I,N.	
P 6 2 2 2 3 3 0	
EPORT OF SERVICES.	December 1
Date of Services Place of Services Description of Services Rendered	Procedure 1CD9/CPT4 Charges
	Total
UTHORIZATION TO PAY BENEFITS TO HEALTH CARE PROVIDER: I hereby authorize payment directly to the Health Care Pr	Ouidae urbana a servicio de la constanta de la
	uviuer whose signature is above.
Member's signature	Date

NOTICE	
MPCHTANT: Jse this form and when the Management of the second of the sec	
PART B HEALTH CARE PROVIDER'S STATEMENT (please crint or type)	
The health care drovider's statement most be filled in completely and mailton to type!	
The health care provider's statement must be filled in completely and mailed to the Fund or returned to the member within seven (7) days of receipt to the form For the pregnancy, enter estimated delivery date under "Remarks." 1. Member's Name 1. Member's Name	-
1. Member's Nama	363 363
- Diagnosistanalysis () Miggie 2 Ace	
ICCOUNTY CODE	ile
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weakness when value-cosed sensibility with	
Jacob Sensibility Whand	_
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Compression at erom compression at wrist I whan a e	₹
s. If disability is a result of pregnancy, give approximate date of conception:	برسي
5. Member hospitalized?	•
17 1941	•
Name of Hospital 12 on To the Homes that	
hansprant and a ransprant	_
Ma I was the street of the disables.	7* - 50. 31
b. Date of your most recent treatment for this disability. C. Date member was unable to work because of this disability.	
c. Date member was unable to work because of this disability d. Date member will be able to perform usual work / 2 / 3	
7	
(Even if considerable question exists, estimate date. Avoid use of terms such as unknown or undetermined.)	
In your coinion, is this disability the result of injury ansing cut of and in the course of employment or occupational disease? Yes 10	
REMARKS (attach additional sheet, if necessary)	
laffirm that I ama (hysician	
Physician Padianes de Licensed in the Cine of	
Specially Account the form	
Health Care Provider's signature WCB Rating No.	
118/4	_
Office address 733 Paril 1 1 1 1 1 1 1 1 1	
Number Down + N. M.	
Indv. Practitioner's SS No.	
7162 216 3332 All others T.I.N.	
ORT OF SERVICES.	
219 D. Sarvicas Place of Sarvicas	
Description of Services Rendered Procedure	
CDA/CP14 Charges	
2.2000	
CCSOSS Total	••
CRIZATION TO PAY SEMEFITS TO HEALTH CARE PROVIDER: I hereby authorize cayment directly to the Health Care Provider whose signature is above.	
ember's signature	
Date	
Date	

Member's Name: Roni Giladi Employed at: A.E.C.O.M. Soc. Sec. No.: 112-64-3264 Date: June 27, 1992 **Member: Member: Member: June 27, 1992 **Member: June 27, 1992 **Me	-		
Soc. Sec. No.: 112-64-3264 Date: June 27, 1992 ***Member: And in receipt of your alaim for benefits. In order to process you it is necessary for you to complete this form and sign it. ***Years of illness or accident: ***********************************			Member's Name: Roni Giladi
Date:			Employed at: A.E.C.O.M.
Member: Which is recessary for your olaim for benefits. In order to process you not it is necessary for you to complete this form and sign it. Next Act il ness or accident: Which will il ness or accident coour? Give complete detail dates: September 5, 1987 Initially the injury for related? Yes: No: Which wilder injury for related? Yes: No: Which wilder injury for related? Yes: Which wilder injury f			Soc. Sec. No.: 112-64-3264
The receipt of your olaim for benefits. In order to process you have not in recessary for you be complete this form and sign it. Yard. It is necessary for you be complete this form and sign it. Yard. It is necessary for you be complete this form and sign it. Yard. It is necessary for you be complete this form and sign it. Yard. It is illness or accident boour? Give complete detail dates: Geptember 5, 1987 Indicate: Geptember 5, 1987 Indicate: No: Are you taking a legal action? If answer is "no", state why: Do you, your spouse, or dependent have any other insurance which becomes his claimyes_XXno. If "yes", give name of company or which is give the above information. If you need assistance regarding the ve, please call the Benefit Fund Office at 307-7500 Extension		•	Date: June 27, 1992
National filtness or accident: The and where diffillness or application occur? Give complete detail dates: September 5, 1987 This illness or injury job related? Yes: No: No: No: No: No: No: No: No: No: No]eu:	r Mencept	
cates: September 5, 1987 Inis illness or injury job related? Yes: No: Indicate Thusband's place of employment: The you taking a legal action? If answer is "no", state why: Do you, your spouse, or dependent have any other insurance which covers this claimyes _XXno. If "yes", give name of company or shion: will be able to process your application for benefits as soon as we sive the above information. If you need assistance regarding the ye, please call the Benefit Fund Office at 307-7500 Extension— ilure to respond timely may result in non-payment of your claim.	oin.	in. It is necessary for	r you so complete this form and sign it.
This illness or injury jot related? Yes:No: No:			
The you taking a legal action? If answer is "no", state why: Do you, your spouse, or dependent have any other insurance which covers this claim			
els. "It: Are you taking a legal action" If answer is "no", state why: Do you, your spouse, or dependent have any other insurance which covers this claimyes _XXno. If "yes", give name of company or union: will be able to process your application for benefits as soon as we sive the above information. If you need assistance regarding the ve, please call the Benefit Fund Office at 307-7500 Extension		tim (midele) inusi	band's blase of employment:
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Are you taking a legal action? If answer is "no", state why: Do you, your spouse, or dependent have any other insurance which obvers his claimyesKX no. If "yes", give name of company or union: will be able to process your application for benefits as soon as we sive the above information. If you need assistance regarding the ye, please call the Benefit Fund Office at 307-7500 Extension time to respond timely may result in non-payment of your claim.			
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will be able to process your application for benefits as soon as well the above information. If you need assistance regarding the ve, please call the Benefit Fund Office at 307-7500 Extension.		*****	
ve, please call the Benefit Fund Office at 307-7500 Extension.	,	ocvers this ulaim	yes <u>XX</u> no. If "yes", give name or
	Ne peo ato	will be able to proces sive the above informa we, please call the Be	s your application for benefits as soon as tion. If you need assistance regarding the nefit Fund Office at 307-7500 Extension
Fraternally yours,			
		,	Fraternally yours,
	÷ F a	illure to respond simel	

Member's Signature

coe:1199 3 NBF 19(Rev. 12/85)P

DETACH THIS PORTION FOR YOUR RECORDS

9 MEDICAL PLAN A+

11/91

.oyee Information

RONI GILADI P O BOX 127 MILLBURN Patient's Name RONI GILADI Social Sec. No. 112-64-3264

Account No. **2214**Claim No.

\$12100291-00

NJ	07041	χ
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PROVIDER	TOS	DATE FROM — TO		TOTAL	BASIC	and the state of t	a 2	TOTAL		
THO VIDE COME	100	FROM — TO	新型於	CHARGES	ALLOWED	ALLOWED	DED.	%	BENEFIT	BENEFIT
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e of Service e Description		TOTAL	.s ♦	250.00	48.00	48.00	0.00		38.40	86-40

INITIAL CONSULT- SURGERY SURGERY

20550

 COB Adjustments
 0.00

 Other Adjustments
 0.00

 Total Payment Amount
 86.40

 Paid to Member
 0.00

 Paid to Provider
 86.40

 Non-Covered
 154.00

 Paid by Other Carrier
 0.00

marks

NO. 965451

OFFICE VISITS PERFORMED ON THE SAME DAY AS THERAPEUTIC PROCEDURE(S) ARE INCLUDED IN THE ALLOWANCE FOR THE PROCEDURE(S).
MAXIMUM BENEFIT PAID ACCORDING TO THE PLAN'S SCHEDULE OF ALLOWANCES.

DETACH THIS PORTION FOR YOUR RECO

an 39 MEDICAL PLAN A+ te 317/91

uployee Information

RONI GILADI P O BUX 127 MILLBURN Patient's Name RONI GILADI Social Sec. No. 112-64-3264

Account No. 2214
Claim No.

\$12210329-00

NJ 07041

PROVIDER	TOS*	PROM — TO	TOTAL CHARGES	BASIC	ALLOWED	MAJOR MEI	DICAL:	BENEFIT	TOTAL BENEFIT
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1 1									
*Type of Service Code Description		TOTALS •	50.00	27.50	4.50	0-00		4.50	32.0

DS FOLLOW-UP SPECIALIST VISIT

COB Adjustments
O • C
Other Adjustments
O • C
Total Payment Amount
Paid to Member
Paid to Provider
Non-Covered
Paid by Other Carrier
O • C

NO. 982782

iode Description

SUPPLIANCE FOR COLOR BESIDERS

· · Remarks

3 MAXIMUM BENEFIT PAID ACCORDING TO THE PLAN'S SCHEDULE OF ALLOWANCES.

DETACH THIS PORTION FC= YOUR RECO

199 MEDICAL PLAN A+

nte /08/93

nployee Information

Patient's Name - RONI GILADI

Social Sec. No. 112-64-3264

Account No.

2214

Claim No. \$30360906-00

RONI GILADI P 0 BGX 127 MILLBURN NJ 07041

PROVIDER	TOS.	DATE FROM TO	TOTAL CHARGES	BASIC	ALLOWES T	MAJOR MEL			TOTAL
AUCH	να	011573-011593	·····	ALLDHED 13.75	ALLOWED 3.75	0 • 0 0	100	BENEFIT 3.75	TOTAL BENEFIT
		·							
					·				* *
e of Service de Description		TOTALS •	50.00	13-75	3.75	0.00	_	3.75	17•5c

COB Adjustments	0.00
Other Adjustments	0-00
Total Payment Amount	17.50
Paid to Member	0.00
Paid to Provider	17.50
Non-Covered	32.50
Paid by Other Carrier	0.00
	5400

emarks

NO. 2268599 PROVIDER DID NOT INDICATE HIS/HER SPECIALTY. HAVE PROVIDER INDICATE SPECIALTY IN SPACE/RETURN TO PO BOX 781 NY 10018-6596.

DETACH THIS PORTION FOR YOUR RECC

Plan

.199 MEDICAL PLAN A+

18/13/92

Patient's Name RDNI GILADI

Social Sec. No. 112-64-3264

Account No. 2214

Claim No. A 2 08 5 0 4 5 5 - 01

Employee Information

RONI GILADI P 0 BOX 127 MILLBURN NJ "07041

PROVIDER	TOS.	DATE FROM — TO	TOTAL	BASIC		MAJOR ME	DICAL		TOTAL
		FHOM — 10	. CHARGES	ALLOWED	ALLOWED	DED.	%	BENEFIT	BENEFIT
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TRAUCH	SU	121291-121291		479-00	383.20	0.00	100	383-20	862-7
STR AUCH	SU	121291-121291	2,500.00	524-45	419.56	0.00	100	419.56	944.0
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			,]						*******
Type of Service Code Description		TOTALS •	8 500 -00	1,578.45	1,262.76	0.00		1,262.76	2,841.2
U SURGER	ł Y		<u>V</u>	64718	COB Adjustment	s			0.(
					Other Adjustmen	ts		•	0-(
		/ K)		Total Payment A	mount			2,841.
		190	R		Paid to Member				0.(
			L		Paid to Provider				2 • 841 • 1
			~		Nam Carres I				E 4E9 '
		5	\		Non-Covered				5,658.

Code

Description

1798282

MAXIMUM BENEFIT PAID ACCORDING TO THE PLAN'S SCHEDULE OF ALLOWANCES. P1

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PLEASE DETACH AT ABOVE PERFORATION

EXPLANATION OF BENEFITS

National Benefit Fund 310 West 43rd Street New York, N.Y. 10036

MEMBER > RONI V GILADI SSN 112-64-3264 PATIENT | RONI V GILADI

EMPLOYER > 001099

CLAIM NUMBER > \$40560273 CHECK NUMBER > 00907621 DATE OF CHECK 05/18/1994 BENEFIT PLAN MEDICAL

SEE BACK OF FORM FOR A LISTING OF EXPLANATION CODES OR IF YOU HAVE ANY QUESTIONS.

Procedure Dates of Service Svc. Type - Provider	Total Charge	Basic Allowed	Allowed	Expl. Code	
99212 10/06/93-10/06/93 F/U VISIT SPECIALIST - STRAUCE	50-00	32.00	-00		32.

TOTALS

32.0

000AL 1194 HATIONAL BEHEFTT FUND JIO MEST 47nd STREET HEN YORK HY 10036

						н	CHECK	I INSURANC	CE CLA	AIM FORM	A	PORM APPROVED CMB NO DESTRICCE				
MEDICARE IMEDICARE NO.1		EDICAID IEDICAID NO.)		AMPUS ONSOR'S SSN)	CHAMPVA (VA FILE NO.)			FECA BLACK	K LUNC	* * * *		OTHER CERTIFICATE SSNI				
				INSURED (S		INFORM	IATI						<u></u>			
I. PATIENT'S NAME ILAST N	IAME, FIRS	T NAME, MIDDLE INITI	ALI	Z. PATIENT'S DATE	OF BIRTH	3, 18	SURE	'S NAME (L	AST N	NAME, FI	RST NA	ME, MIDDLE INIT	IALI .			
GILADI, RON	<i>)</i>			05	05 52	10	Y 1.4	27. 8	105	I						
4. PATIENT'S ADDRESS (ST	REET, CITY,	STATE, ZIP CODE)		5. PATIENT'S SEX		6. IN	SURE	'S I.D. NO.	(FOR F		A CHEC	KED ABOVE,				
P.J. SJK 12	7			MALE Y	FEMAL	_ .	112643264									
MILLBURN NO		47		6.77	السيا د	* '	ب نہ ت	THE COLD TO SERVICE	'							
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				SELF SPOU	SE CHILD	OTHER		INSURED) IS EM	PLOYED AND	COVERE	D SY EMPLOYER				
7ELEPHONE NO. 9. OTHER HEALTH INSUFANCE COVE	AGE (ENTER)	NAME OF POLICYHOLDER AND		10. WAS CONCITION REL	ATEO TO:	11 INS	INSURED IS EMPLOYED AND COVERED BY EMPLOYER HEALTH PLAN 11. INSURED'S ADDRESS ISTREET, CITY, STATE, ZIP COCE)									
PLAN NAME AND ADCRESS AND F	OLICY OR ME	DICAL ASSISTANCE NUMBER		le: The continue it.	54 ED 10.				-							
				A. PATIENT'S EMPLOYME		- 1 P	.0.	BCX.	12	7						
MONE REPORT	$\mathcal{E}\mathcal{D}$			YES	NO NO	M.	I i. L	BURN	MJ	Q74	14.					
						TE	LEPHONS	NO.								
				B. ACCIDENT		11.a,	·		CHAMI	PUS SPONS	OA'S :					
		•		AUTO	OTHER -	STATU	ıs i	ACTIVE		DECEAS	ED S	RANCH OF SERVICE				
				<u></u>				RETIRED)							
12. PATIENT'S OR AUTHORIZED PERSON I AUTHORIZE THE RELEASE OF AR	NA MEDICYT IN	IFORMATION NECESSARY TO :	PROCESS THIS	S CLAIM, I ALSO REQUEST S	PAYMENT	13, 1 A	UTHORI	E PAYMENT OF OR SUPPLIER F	MEDIC	AL BENEFITS	TO UNDE	IRSIGNED DW.				
OF GOVERNMENT BENEFITS EITH	ER TO MYSELF	OR TO THE PARTY WHO ACC	EPTS ASSIGN	MENT BELOW.				ATURE	•							
SIGNED SIGNATU	RE O	N FILE		DATE	02/26											
			PHYSIC	IAN OR SUP												
14. DATE OF:	ILLNESS '	FIRST SYMPTOM) OR INJUI		S. DATE FIRST CONSULT		16. IF	16. IF PATIENT HAS HAD SAME OR 16.6. IF EMERGENCY									
•	IACCIDEN	ITTOM PREGNANCY (EMP)	- 1	CONDITION		Si	IMILAR	CLNESS OH IN	JURY, (GIVE DATE:	5	CHECK HERE				
17. DATE PATIENT ABLE TO	18. DATE	ES OF TOTAL DISABILITY	J			DATES	OF PAR	TIAL DISABILI	ΤΥ							
RETURN TO WORK]		1_							1						
19. NAME OF REFERRING PHYSICI	AN OR OTHE	R SOURCE (e.g. PUBLIC HEA		HAOUGH		FROM 20. F	OR SER	VICES RELATE	р то н		OUGH ATION GIV	VE				
				•		Н	IOSPITAI	IZATION DATE	5]		,-				
21. NAME AND ADDRESS OF FACE	I ITV WIDER	CEDIVICES BENDEAD UE O	TUER TUAN	HOME OF OCCUPA		ADMIT		ORATORY WO	OV DED		CHARGEO					
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HONTIFIORE 23. A. DIAGNOSIS OR NATURE OF	M.E. U.J.	SAL CENTER	₹ .3°.3°.	<u> 51 BAIMBR</u>	<u>IDGE AVE.</u>	YE		B. NO	CHAR			···				
ETC. OR OX CODE							- I	۵,								
<u>.</u>		C&REPAIR :		AN N. F⊸A	RM		-	EPS	SDY		YE	s No				
	AKNE:	SS L. HANS	9				FAMILY PLANNING YES NO									
3.																
4, .				1.		_	'	AUTHORIZATI	ION NO	١			·			
24. A. DATE OF SERVICE	PLACE	FURNISHED FOR EAC	DCEDURES, I	MEDICAL SERVICES OR SI 'EN	UPPLIES	0.				F. DAYS		H. LEAVE BLANK				
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THIS BILL AND ARE MADE A	TARE THERE	<i>i</i> . <i>D</i>	~ 			ĺ		100			0 1		<u>00</u>			
Spicial BERISH ST	y: 10	aby Richau	سدره	YES XX	ON	31. P	HYSICIAND TEL	N'S, SUPPLIE	R'S, AN	D/OR GRO	UP NAME	ADDRESS, ZIP CO	DE			
BERISH ST	RAUC	н, м.р.	· I	30. YOUR SOCIAL SE	CURITY NO.			SH ST	TRA	йсн	. B	.D.				
		**						BAII								
DATE: 02/26/9	j					α ا	en.	W WV	11	1117						
32. YOUR PATIENT'S ACCOUNT N				33. YOUR EMPLOYER	I.D. NO.	5	ハロド	18 1917 21 1919:	2 (J m . m	/46/ :=:=:/	0	0 609 5	Ś			
2214				05226		I.D.(N	ند که ۱۵۷	1 720	V-:	1001	O,		~			
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				Q45H(1/4+1)	DE MANDELLINGUE		*** 1 F F F F				- 4.					

LOCAL 1199 NATIONAL SENEFIT FUNC P.O. BOX FOX HEW YORK NY 10018

							HEALTH INSURANCE CLAIM FORM ICHECK APPLICABLE PROGRAM BLOCK BELOW! ONE NO STATEMENT ONE STATEMENT ONE STATE									
MEDICARE NO.	<u> </u>	MI IM	EDICAID EDICAID NO.)	LISI	AMPUS PONSOR'S SSNI	CHAMPVA (VA FILE NO.			FECA BLAC	K LUN	g XX		OTHER (CERTIFIC			
1 PATIENT'S NAME (AST N	AME FIRS	PATIEN T NAME, MIDDLE INITI	TAND	INSURED (S		INFO	RMAT	ION							
					1	1	1	i, ingun	ED S NAME I	LASI	NAME, PI	AST NA	AME, MIDI	DLE INITIAL)		
4. PATIENT'S ADDRES			STATE, ZIP CODE)		5. PATIENT'S SEX	<u>05 52 </u>		6. INSURED'S LO. NO, IFOR PROGRAM CHECKED ABOVE								
P.O. BOX					. MALE	FEMA	j	6. INSURED'S I.D. NO. IFOR PROGRAM CHECKED ABOVE. 112643264								
HILLBURN	НJ	070	et 1		7. PATIENT'S RELATIONS	- 8		GROUP NO. (OF		NAME OR	FECA CU	AIM NO.1				
	٠				SELF SPOUS	E CHILD	ОТНЕЯ	я								
9. OTHER HEALTH INSURANCE	E COVER	AGE IENTER N	IAME OF POLICYHOLDER AND		10. WAS CONDITION REL	ATED TO:	<u> </u>	INSURED IS EMPLOYED AND COVERED BY EMPLOYER 11. INSUREO'S ADDRESS ISTREET, CITY, STATE, ZIP CCDE								
FEAR MAINE AND ADDRES	is and re	JCICT ON INCL	NOAL ASSISTANCE NUMBERS		A. PATIENT'S EMPLOYME	uT		8.0	. BOX	12	779					
HONE REP	ORT.	ED			YES		MIL	LBURN		•	241	,				
					R. ACCIDENT		ļ.,	TELEPHO!	NE NO.	CHAM	PUS SPONS	OB'S				
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I AUTHORIZE THE RELEAS	SE OF ANY	Y MEDICAL IN	RE IREAD BACK BEFORE SIGN FORMATION NECESSARY TO OR TO THE PARTY WHO ACC	PROCESS. THI	S CLAIM, I ALSO REQUEST P	15	1. I AUTHOR PHYSICIA	RETIREI		AL BENEFIT	S TO UND	ERSIGNED-				
				ri ia MagiuN	SIGNATURE ON FILE											
SIGNED STIGHT	41 (1)	RE = OI	N FILE	DUVCIO	DATE CLUD	07/22			RED OR AUTHOR	IZEO PE	RSONI		·	······································		
14. DATE OF:		ILLNESS (FIRST SYMPTOM) OR INJU		SIAN OR SUPI				NT HAS HAD S	AME OF	· · · ·		16.a. IF EME	BOENCY		
17. DATE PATIENT ABLE TO		IACCIDEN	T) OR PREGNANCY (LMP)		CONDITION			SIMILAR ILLNESS OR INJURY, GIVE DATES CHECK HERE								
RETURN TO WORK	•						l°	ATES OF PA	ATIAL DISABILI	TY	1					
19. NAME OF REFERRING	PHYSICIA	N OR OTHER	SOURCE leg, PUBLIC HE		HROUGH			ROM O. FOR SE	RVICES RELATE	о то н		OUGH ATION G	IVE			
C. HALL					•		١.	HOSPITA DMITTED	ALIZATION DAT	ES	1					
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MONTIFIO	7 <i>F</i> N	45D77	AL CENTER	<u> 7.7.</u>	U RAINBR	IDGE AVE		YES	NO NO	CHAR	GES:					
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24. A.		8. +	C. FULLY DESCRIBE PRI	OCEDURES, I	AEDICAL SERVICES OR SU	-1	•	AUTHORIZAT	טא אטו	· 		I H. LEAVE	RI ANK			
DATE OF SERVICE	то	PLACE OF SERVICE	PROCEDURE CODE	7			DIA	D. GNOSIS	ε,		DAYS OR	G. *				
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07/19/81		0	20550	INJE	CTION, L	EFT		*·*					1.			
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				}					-				}			
25. SIGNATURE OF PHYSIC CREDENTIALS) (I CERT THIS BILL AND ARE M	IAN OR : IFY THAT ADE A PA	SUPPLIER (IN THE STATE) ART THEREO	HCLUDING DEGREEIS) OR MENTS ON THE REVERSE	APPLY TO	26. ACCEPT ASSIGNM CLAIMS ONLY) (SE	ENT (GOVERNMENT E BACK)		7. TOTAL	CHARGE	 	28. AMC	UNT PA	ID 29.	BALANCE DUE		
Specialty	/ زر	PLAS	4 Recon Sc	LN Q	YES]	-	1. PHYSIC	257) AN'S, SUPPLIE		D/OR GROV		777	250 00		
BERISH	I '' STI	RAUCE	1, M.D.	4	30. YOUR SOCIAL SEC	<u> </u>		AND IE	LEPHONE NO.					, LIF GODE		
	•				"			333.	ISH ST U BAII	in A VB#	TOGE	, ⊓ - ∆	v.F.			
DATE: 07/2:	2/9)								YX XY					10 C		
32. YOUR PATIENT'S ACCO					33. YOUR EMPLOYER I	D. NO,	\Box		2) 920			C	US)96		
PLACE OF SERVICE AND	YPE OF	SERVICE IT	S.) CODES ON THE BACK	····	06226			· · <u>·</u> ·	11052 1-	200						
2. 04			4.1 1110 0-1010		APPHOVEN F	M WW CUNNUI	ı	Form	HCFA-15	on re	3-21 /1-	841	Form 0	WCP-1500		

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	 -							HEALTH INSURANCE CLAIM FORM ICHECK APPLICABLE PREGRAM BLOCK BELOW OMB NO 0938-3024							
MEDICARE (MEDICARE NO.)		EDICAID MEDICAID NO.)	(S	HAMPUS PONSOR'S SSNI	CHAMPVA (VA FILE NO.			FECA BLAG				OTHER (CERTIFICATE SSN)			
1. PATIENT'S NAME (LAST !	NA BAE PIE	PATIEN	TAN	NSURED (SU	BSCRIBER)	INFO	VFORMATION								
I. PAHENT'S NAME (LAST	NAME, FIRS	T NAME, MIDDLE INIT	IALI	2. PATIENT'S DATE O	FBIRTH		3. INSUF	ED'S NAME	(LAST	NAME, FI	RST NA	AME, MIDDLE INITIALI			
4. PATIENT'S ADDRESS IST	II	STATE TIP COOK			CT (70		GTI		<u>0 2</u> 2						
		SIAIE, ZIP CODE)		5. PATIENT'S SEX	F		6. INSUR	ED'S I.D. NO. DE ALL LETT	(FOR	PROGRA	M CHEC	CKED ABOVE.			
- P.O. ROY 12				MALE V	FEMA	ALE	112	54325.	ijĹ						
MILLBURN NO	7 070	41		7 PATIENT'S RELATIONSHIP											
				ANIENI S RELATIONSHIP	IO INSURED		B. INSUREO	S GROUP NO. IO	A GACI	P NAME OR	FECA CLA	IM NO.)			
				SELF SPOUSE	CHILD	OTHER									
9. OTHER HEALTH INSURANCE COVE PLAN NAME AND ADDRESS AND	RAGE IENTER	NAME OF POLICYHOLDER AN	<u> </u>	10. WAS CONDITION RELATE	in TO:	<u> []</u>		HEALIT	1 PLAN			ED BY EMPLOYER			
PLAN NAME AND ADDRESS AND	POLICY OR ME	DICAL ASSISTANCE NUMBER)	_		10 10.	ļ		S ADDRESS (ST			P CODEI				
NONE REPORT	e v.			A. PATIENT'S EMPLOYMENT	NO NO	.	$P \cdot O$. 30X	1.	ア					
CONE REPORT	20			1 150		MIL	LBURN	M_{ν}	7 070	14:					
				B ACCIDENT		·	TELEPHO	NE NO.							
				AUTO	OTHER	F	ILL. CHAMPUS SPONSOR'S :								
					L OTHER		STATUS	DUTY	L	DECEAS	ED E	BRANCH OF SERVICE			
12. PATIENT'S OR AUTHORIZED PERS I AUTHORIZE THE RELEASE OF AI OF GOVERNMENT BENEFITS EITH	ON'S SIGNATU	RE (READ BACK BEFORE SIGN	(BNE				3. I AUTHO	RETIRE		CAL BENEFITS	TO UNO	EBEIGNED			
OF GOVERNMENT BENEFITS EITH	EA TO MYSELF	OR TO THE PARTY WHO ACC	EPTS ASSIGN	IS CLAIM. I ALSO REQUEST PAYN IMENT BELOW.	MENT			IZE PAYMENT O N OR SUPPLIER				ÓM'			
SIGNED STGNATU	IRE D	N F7/F		DATE	~ ~			IATURE			LE				
	· · · · · · · · · · · · · · · · · · ·		PHYSIC	CIAN OR SUPPL	IER INFOR			NEO UR AUTHOR	IZED P	HSON)	 -				
14. DATE OF:	ILLNESS (FIRST SYMPTOM) OR INJU T) OR PREGNANCY (LMP)		15. DATE FIRST CONSULTED CONDITION			8. IF PATIE	NT HAS HAD S	AME C)R		IB.a. IF EMERGENCY			
	•	(400)		00/10/10/4			SIMILA	I ILLNESS OR II	NJURY,	GIVE DATES	· [CHECK HERE			
17. DATE PATIENT ABLE TO RETURN TO WORK	18. DATE		······································			DATES OF PA	RTIAL DISABIL	TY							
	FROM		THROUGH		١,	ROM	•		THRO	nicu					
19. NAME OF REFERRING PHYSICI	AN OR OTHE	SOURCE Ing. PUBLIC HEA	AUTH AGENC	YI			O. FOR SE	RVICES RELATE	0 10			VE			
						L.	ADMITTED	TENION DATE	-9	l nier	HARGE	,			
21. NAME AND ADDRESS OF FACE	LITY WHERE	SERVICES RENDERED IIF O	THER THAN	HOME OR OFFICE		- 1	Z. WAS LA	BORATORY WO	RK PE						
23. A. DIAGNOSIS OR NATURE OF	WFDI(AL CENTER	7.7.6	T BATHRETI	GE AVE	_ F	YES	∏., NO	CHAP	GES:					
						2. 3.		8.							
_ 700.x S/				AN N. F-AE	H			€P:	SDT		YE	5 NO			
1 754.0 ET	L MEI	DIAN NERVE	E 00%	<i>HPRESSION</i>				FA	MILY P	LANNING	YE	S NO			
4.							PRIOR AUTHORIZATION NO.								
24, A,	B. *	C. FULLY DESCRIBE PRO	OCEDURES.	MEDICAL SERVICES OR SUPPL	IEC	- -	•	AUTHORIZAT	וא אט). 		1.00			
DATE OF SERVICE	PLACE OF SERVICE	PROCEDURE CODE	H DATE GIV	EN .		l Dia	D, GNOSIS	_		F. DAYS		H. LEAVE BLANK			
07/31/91	O	POOSO		AIN UNUSUAL SERVICES OR C		 '	CODE	CHARGE	i	OR UNITS	G. 7.O.S.	1			
	· ·	70060		ICE MEDICA		955		1	!			14			
			<u> C. F </u>	<u>ESTABLISHE</u>	D PT	35	1-0	50	<u>100</u>		_2_				
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25. SIGNATURE OF PHYSICIAN OR CREDENTIALS) (I CERTIFY THAT THIS BILL AND ARE MADE A P.	SUPPLIER IN	CLUDING DEGREES) OR MENTS ON THE REVERSE	APPLY TO	26. ACCEPT ASSIGNMENT CLAIMS ONLY) ISEE BA	GOVERNMENT	1. 2	7. TOTAL C	HARGE	-	28. AMOL	INT PAIC	29, BALANCE DUE			
THIS BILL AND ARE MADE A P	ART THEREO)		CEMING ONLY 19EE BA	··········						_ 1				
Spicialty Pl BERISH STI	asy F	uein suid		YES (NO	3	I. PHYSICI	AN'S, SUPPLIER	'S, AN	D/OR GROU	NAME,	ADDRESS, ZIP CODE			
' BERISH ST	RAUCH	1. M.D.		30. YOUR SOCIAL SECURI	TY NO.										
	w. ()					1		SH ST							
DATE: 08/05/9								BAIN							
32. YOUR PATIENT'S ACCOUNT NO				33. YOUR EMPLOYER I.D. N	10.		4 W 21 CL ** 4 MKvn.	IX NY	10	467	C	08097			
2214				0622633	V.30		~(°¥″./ .:	V 920	/ S	351	•				
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LOCAL 1199 NATIONAL BENEFIT FUND F.O. BOX 781 NEW YORK NY 10018
HEALTHINSURANCE CLAIM FORM
HEALTHINSURANCE CLAIM FORM

MEDICARE (MEDICARE NO.)	ME (M	DICAID EDICAID NO.)	CH (SF	AMPUS PONSOR'S SSNI	CHAMPVA (VA FILE NO.)		CAECK	FECA BLAC	K LUNG	XX [OTI	HER RTIFICATE SSNI
1. PATIENT'S NAME LAST N	AME, FIRST			INSURED (SUB		INF			AST N	AME. FIR		, MIDDLE INITIAL)
GILADI. ROM		-		c3 n5	1	Ì		DI. 8				THE SEE MITTINE
4. PATIENT'S ADDRESS (STE		STATE, ZIP CODEI		5. PATIENT'S SEX			6. INSURE	D'S I.O. NO. E ALL LETTE	(FOR P		CHECKE	D ABOVE,
8.0. BOX 13	•			MALE	FEMAL	.E	1126	43254				
MILLEURN NJ	0704	- 1,		7. PATIENT'S RELATIONSHIP TO	O INSURED		8. INSURED'S	GROUP NO. IOR	GROUP	NAME OR FI	CA CLAIM	NO.1
				SELF SPOUSE	CHILD C	OTHER						
TELEPHONE NO.	ACE IENTER V	THE OF BOLLCYHOLDER AND		;			11 (1)(1)	HEALTH	PLAN			Y EMPLOYER
9 OTHER HEALTH INSURANCE COVER PLAN NAME AND ADDRESS AND F	OLICY OR MED	DICAL ASSISTANCE NUMBERI	•	10. WAS CONDITION RELATED	IO:		11. INSURED'S				CODE	
NONE REPORT	ΞĐ			A. PATIENT'S EMPLOYMENT YES		XO3 NRUB			4.1			
Time Cine Tiber to the Conference of the					YES X NO							
				B. ACCIDENT	RAHTO		11,0.	ACTIVE	CHAMP	US SPONSO	1	NCH OF SERVICE
		• •			L 0,,,,,,		STATUS	ACTIVE DUTY RETIRES	, L	DECEASE		Tan or senting
1Z. PATIENT'S OR AUTHORIZED PERSO I AUTHORIZE THE RELEASE OF AN OF GOVERNMENT BENEFITS EITH	ON'S SIGNATUR Y MEDICAL IN	HE IREAD BACK BEFORE SIGNIFORMATION NECESSARY TO	NGI PROCESS THI	IS CLAIM. I ALSO REQUEST PAYME	INT		13. I AUTHORI PHYSICIAN	ZE PAYMENT OF	MEDICA FOR SERV	L BENEFITS	TO UNDERS	IGNEO
			EPTS ASSIGN	MENT BELOW.				ATURE			E	•
SIGNED STANATU	RE ON		HYSIC	CIAN OR SUPPLI	10/08/			ROHTUA RO DE	ZED PER	SONI		
14. DATE OF:	15. DATE FIRST CONSULTED Y		VIX	16. IF PATIEN	T HAS HAD S	AME OR	IVE DATES	16.2	IF EMERGENCY CHECK HERE			
-		T) OR PREGNANCY ILMPI					~				L_	
17. DATE PATIENT ABLE TO RETURN TO WORK		S OF TOTAL DISABILITY	1				DATES OF PAR	RTIAL DISABILI	Τ¥	ļ		
19. NAME OF REFERRING PHYSIC	AN OR OTHER	SOURCE (e.g. PUBLIC HEA		THROUGH :YI			20. FOR SER	VICES RELATE	D TO HO	THRO SPITALIZA		·····
	·			· · · · · · · · · · · · · · · · · · ·			ADMITTED	12/12	191			12/13/91
21. NAME AND ADDRESS OF FACE					ester Alien	y	22. WAS LA	BORATORY WO	CHARG		JT\$IDE YO	UR OFFICE?
23. A. DIAGNOSIS OR NATURE OF]5 2, 3,		B.			·····	
	RPAL	TUNNEL SY	MDR0	DME				ÉP	SDT		YES	NO
2. 3.							Ĭ	FA	MILY PL	ANNING	YES	
4.				•			*	PRIOR AUTHORIZAT	 ON NO.			
24. A. DATE OF SERVICE	B. + PLACE	C. FULLY DESCRIBE PRO	CEDURES.	MEDICAL SERVICES OR SUPPLI	EŞ	7	D.			F. DAYS		I. LEAVE BLANK
FROM TO	SERVICE	PROCEDURE CODE		AIN UNUSUAL SERVICES OR C		0	CODE	E. CHARGE	s	OR UNITS	G. • T.O.S.	
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25. SIGNATURE OF PHYSICIAN OF CREDENTIALS) (I CERTIFY TH THIS BILL AND ARE MADE A	R SUPPLIER (II AT THE STATE PART THEREC	NCLUDING DEGREE(S) OR MENTS ON THE REVERSE OFI	APPLY TO	26. ACCEPT ASSIGNMENT CLAIMS ONLY) ISEE BA	(GOVERNMENT ACK)		27. TOTAL			28. AMO		29. BALANCE OUE
SOCIALTY PLA	ox Ri	en Sura	/	YES X	NO		31, PHYSICI	S() AN'S, SUPPLIE			O DO	DDAESS, ZIP CODE
saucinia 1 cm	, , ,	8		30. YOUR SOCIAL SECURI	لبنا			CEPHONE NO. SH ST				
BERISH STRA	UCH,	M.D.					3331	BAIN	JBR.	IDGE	AUE	-
DATE: 1.0/08/9				33. YOUR EMPLOYER I.O. N	NO.			IX NY			C.	S098
2214				0622633			i.d. wo.l 🗹	920	,-D;	J	. •	· · · · · · · · · · · · · · · · · · ·